megadalton transmissible plasmid,[1] was isolated in the United States of America.[2] These strains of TRNG were found in England and the Netherlands in 1988.[3,4]

We now present the first TRNG isolate in Spain, from a prostitute woman from Madrid; she was treated with spectinomycin. The isolate of *N. gonorrhoeae* was resistant to tetracycline (Minimal Inhibitory Concentration 16 mg/l), sensitive to penicillin (MIC 0·06 mg/l), spectinomycin (MIC 16 mg/l) and ceftriaxone (MIC 0·0015 mg/l), and moderately sensitive to cefoxitin (MIC 0·5 mg/l).

The plasmid analysis[5] shows two plasmids, of 25·2 and 2·6 megadaltons; digestion of plasmid deoxyribonucleic acid with Hinc II and Sma I shows a band pattern different from the one found when a 24·5 megadalton plasmid (transfer plasmid) was digested.

Auxotype and serotype were determined as has been previously described;[6] the isolate belonged to class-Pro/Bpyst.

A rapid international spread of TRNG may be occurring as we predicted recently.[7]

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1 Morse SA, Johnson SR, Biddle JW, Roberts MC. High level tetracycline resistance to *Neisseria gonorrhoeae* is result of acquisition of streptococcal tet-M determinant. *Anti-microb Agents Chemother* 1986;30:664–70.
2 Knapp JS, Zenilman JM, Biddle JW, *et al.* Frequency and distribution in the United States of strains of *Neisseria gonorrhoeae* with plasmid mediated high level resistance to tetracycline. *J Infect Dis* 1987;155:819–22.
3 Waugh MA, Lacey CJN, Hawker PM, *et al.* Spread of *Neisseria gonorrhoeae* resistant to tetracycline outside the United States of America. *Br Med J* 1988;296:898.
4 Roberts MC, Van Klingeren B, Wagenvoort JHT, Knapp JS. Tet-M, β-lactamase containing *Neisseria gonorrhoeae* (TRNG/PPNG) in the Netherlands. *Antimicrob Agents Chemother* 1988;32:158.
5 Birboim HC, Doly A. A rapid alkaline extraction procedure for screening recombinant plasmid DNA. *Nucleic Acids Res* 1979;7:1513–23.
6 Fenoll A, Berrón S, Vázquez JA. Analysis of penicillinase producing *Neisseria gonorrhoeae* isolates in Madrid (Spain) from 1983–85. *Epidemiol Infect* 1987;99:455–62.
7 Vázquez JA. *Infección gonocócica.* Ministerio de Sanidad, Boletin Microbiológico Semanal 1988;12/88: 1–4.

## Workload in genitourinary medicine clinics in England

One of the criteria used to assess workloads in genitourinary clinics is based on the reports of clinic attendances, that is, new cases, return visits and diagnoses. Yet there does not appear to be an agreed uniform approach to calculating these figures between different clinics, making comparisons of workloads difficult to interpret.

When to reregister patients (and thus create a new visit and a new diagnosis) is an area open to individual interpretation. A dilemma often arises in cases of chronic or recurrent conditions like candidiasis, recurrent non-specific urethritis, genital warts, etc.

Different clinic practices may also contribute to false impressions of workload. For example, considering the fact that many of our patients are employed and/or have young children, we operate a fairly liberal policy of allowing patients to phone for results where the doctor considers this appropriate. This obviously creates a lot of work for reception staff, who still have to retrieve case notes from filing and locate results, and often have to ask a doctor either for a comment or to talk to the patient. Thus, although we are providing an optimal patient oriented facility much of this work is not included in assessment of workload for the clinic. Conversely, a clinic that insists on a visit for results will show higher clinic attendance figures.

A clinic, like ours, that provides a full colposcopy service through to cold coagulation, loop excision or laser therapy, hardly has its workload adequately represented by a single diagnosis of C11 when the patient attends with genital warts and is subsequently managed by us for an abnormal smear. A clinic that does not even do cytology would apparently have a similar workload to us—based on diagnoses alone.

With the imminent National Health Service review and an apparent decrease in clinic attendance numbers, despite increased workload due to the complexity of the current conditions,[1] there is pressure on clinics to institute measures to get numbers to reflect the work being done. In future it is likely that greater credit and resources will be given to clinics that show high new patient attendance numbers and a high new patient to follow up attendance ratio. To our knowledge no consensus on performance indicators in genitourinary medicine has yet been reached but attendance and ratios are likely to be major considerations. It is essential that our practice is represented in a comprehensive, accurate and work sensitive way to reflect true workload and changing trends. Clinic variance in registration and reregistration policies will make comparisons inaccurate and regional planning difficult.

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1 Thin RN. Workloads in genitourinary medicine clinics in England. *Genitourin Med* 1989;65:376–81.

## Syphilis among heterosexuals

We read with interest the paper by Dr van den Hoek and colleagues[1] and have therefore performed a survey to determine whether acquisition of syphilis at our unit is associated with prostitution or drug abuse.

The case notes of all patients attending our clinic between 1985 and 1989 with primary, secondary or early latent syphilis (less than one year's duration) were reviewed retrospectively. The following clinical details were recorded: sex; sexual orientation; history of prostitution; history of drug abuse; whether infection contracted in UK or abroad. These details are summarised in the table.

No patients gave a history of prostitution or drug abuse. As has been noted in other studies the number of homo/bisexual men with infectious syphilis has greatly decreased and the proportion of heterosexuals with infectious syphilis is increasing. But there has been no increase in the number of heterosexuals with syphilis and an increasing proportion of